



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MEMORIAL COMPOUNDING PHARMACY

Respondent Name

AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number

M4-17-1767-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 9, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills are outstanding as we have not received any correspondence from the insurance carrier . . . We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: \$93.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor failed to file its request within one year of the date of service, and has waived the right to medical fee dispute resolution."

Response Submitted by: Flahive, Ogden & Latson, Attorneys At Law, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2016	Pharmacy services – prescription drug dispensed	\$93.28	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out procedures for resolving medical fee disputes.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. This medical fee dispute involves a prescription drug dispensed from the pharmacy to the injured employee on date of service February 1, 2016. The request for medical fee dispute resolution was received by the division on February 9, 2017, which is more than one year following the first disputed date of service.

28 Texas Administrative Code §133.307(c)(1) requires that:

A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

- (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

Review of the submitted documentation finds that the disputed services do not involve issues identified in Rule §133.307(c)(1)(B). The division concludes that the requestor has failed to timely file this dispute with the division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for the items dispensed on that date.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

For the reasons stated above, the Division finds the requestor has waived the right to medical fee dispute resolution. The requestor has failed to support that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted documentation, in accordance with Texas Labor Code §413.031, the division has determined the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

_____ Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	March 10, 2017 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.